If you need assistance completing this application, please ask an Office of Public Assistance staff member.

COMPLETION INSTRUCTIONS:

The Montana Department of Public Health and Human Services (DPHHS) offers several programs to help you. Use this application to apply for Temporary Assistance for Needy Families (TANF) cash assistance, medical assistance or Food Stamps.

1. **If you don't have time to complete the full application now:**
   - **fill in your name and address on the front page;**
   - **sign your name on the front page; and**
   - **turn in only the top copy of the front page today.**
2. If eligible for **TANF cash assistance or Food Stamps**, benefits may start from the date the front page of the application is received. If eligible, **Medicaid** may begin up to three (3) months prior to the month of application.
3. You may be entitled to receive **Food Stamps** within seven days (Expedited Service). See the back of page 1 for details.
4. Complete the entire application to the best of your ability.
5. Please use black or blue ink (it is easy to read and copies best). Print your answers.
6. If more space is needed to answer a question(s), attach an additional sheet with appropriate information about each additional person.
7. The application should be filled out by a household member or an authorized representative who knows the financial situation of all household members. The person completing the application is responsible for the answers given.
8. Any question that refers to “household” is referring to those persons applying for assistance and those financially responsible for them. For Medicaid, you need to enter the social security number and citizenship only for individuals requesting Medicaid.
9. If applying for ***any*** program, complete the front page, questions 1 through 35 and questions 49 and 50, unless otherwise marked (white background).
10. If applying for **Medicaid**, also complete questions 36 through 43 (light blue background). Any question marked with a number sign (#) need not be completed if you are only applying for Medicaid.
11. If applying for **Food Stamps**, also complete questions 44 and 45 (light orange background). Any question marked with an asterisk (*) need not be completed if you are only applying for Food Stamps.
12. If applying for **TANF cash assistance**, also complete questions 46 through 48 (green background).

DPHHS-HCS-250 (Rev. 4/01)

STATE OF MONTANA
Department of Public Health and Human Services

APPLICATION FOR ASSISTANCE

Date Application Received:_____
Case Number_____
Date of Interview: _____
☐ TANF ☐ FS ☐ Ex p. ☐ MA ☐ QMB ☐ SLMB

GRAY SHADED AREAS ARE FOR INSTRUCTIONS AND AGENCY USE ONLY.

Name:_____County:_____
Street Address: _____ City:_____ Zip:_____Day Phone Number:_____
Mailing Address: _____ City:_____ Zip:_____Message Phone Number:_____
Do you live within the geographic boundaries of an Indian Reservation? _____ Yes _____ No
If you do not live at a street address, describe how to get to your home in space provided on page 15.

Fill in all required blanks for everyone who lives with you either permanently or temporarily, whether you consider them household members or not. List yourself first, then your spouse and children, including unborn children, then other adults and children.

NAME (Last, First, Middle)	RELATIONSHIP TO YOU	BIRTH DATE	*PLACE OF BIRTH	*SEX	SOCIAL SECURITY NUMBER	*MARITAL STATUS	U.S. CITIZEN Yes/No
1.	**SELF**						
2.							
3.							
4.							
5.							
6.							

I would like to apply for: _____ Child Support _____ Child Care _____ TANF cash assistance _____ Food Stamps
_____ Medical Assistance _____ Qualified or Special Low Income Medicare Beneficiary Coverage

FOOD STAMP EXPEDITED SERVICE QUESTIONS

What is the total income before deductions your household has received or expects to receive this month? If zero, enter zero. $_____

How much do the members of your household have in cash and savings? (Give your best estimate) If zero, enter zero. $_____

How much is your monthly rent/mortgage? If zero, enter zero. $_____

How much are your current monthly utilities? If zero, enter zero. $_____

Is anyone in your household a migrant or seasonal farm worker? ___ Yes ___ No

Has anyone in your household received Food Stamps in the last 30 days? ___ Yes ___ No
If Yes, where and when? _____

COUNTY USE

Income less than $150 and cash and savings no more than $100? ___ Yes ___ No
(If Yes, expedite)

Combined income and resources less than rent/mortgage and utilities?___ Yes ___ No
(If Yes, expedite)

Destitute migrant/seasonal farm worker with cash and savings less than $100? ___ Yes ___ No
(If Yes, expedite)

Screened for expedited services:___ Yes ___ No
Eligible for expedited services: ___ Yes ___ No
_____ Worker Initial

PENALTY WARNING: I SWEAR OR AFFIRM THAT THE STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND CORRECT.

X_____ _____
SIGNATURE OR MARK OF APPLICANT (OR LEGAL GUARDIAN) DATE

_____ _____
WITNESS TO MARK (NECESSARY ONLY IF APPLICANT CANNOT SIGN FULL NAME) DATE

Distribution: White - County, Yellow - to remain attached to application form

INTERVIEW:

1. After your application is filed, you will be notified of the time and date of your interview (if needed). **An interview is not required for Medicaid. Complete as much of the application as you can.** A worker will help you with any unanswered questions at the interview . If you do not have all necessary information, this could delay a decision on your application.
2. For all programs, if you cannot keep your appointment (if needed), **you must schedule another appointment within 30 days of the application date.** If you do not schedule another appointment, your application will be denied.
3. If you are not able to appear for an interview or you are unable to find someone to represent you, call your local office of public assistance to schedule a home visit or phone interview.

TO GET FOOD STAMPS WITHIN 7 DAYS (EXPEDITED SERVICE):(You may be entitled to expedited services if your income and resources are not enough to cover your monthly rent/mortgage and utilities; or you have very little income or resources; or your household includes a migrant or seasonal farm worker.)

1. Complete the application and provide proof of identity of the person listed as number 1 on the first page.
2. If you do not have time to complete this form now, complete the front page and turn it in now. This will ensure your benefits start from today if you are eligible for Food Stamps.
3. You must complete the application, except questions marked with an astrisk (*), before benefits can be issued.
4. If you are eligible for expedited service, we will give you Food Stamps for this month even if you cannot give us all the proof we need.
5. If you feel you are eligible for expedited service but your worker says you are not, you may ask for an administrative conference. If no resolution occurs, then you may request a fair hearing either orally or in writing.

RIGHTS AND RESPONSIBILITIES:

1. You have the right to file an application on the same day you contact us. You may either leave the entire application or completed front page at the office or mail it.
2. You do not have to be interviewed or have a scheduled appointment before filing the application.
3. Your application will be processed within thirty (30) days from the date of application except in unusual circumstances as defined by regulation.
4. Applicants soon to be released from an institution may make application for Food Stamps prior to their release. The application filing date for prerelease applicants is the date of release from the institution.
5. **For Food Stamps, do not:**
   - **trade or sell Food Stamps;**
   - **use Food Stamps to get ineligible items such as alcoholic drinks and tobacco; or**
   - **use someone else's Food Stamps for your household.**
6. You will be required to repay any benefits that you are not eligible to receive regardless of what or who caused the error.
7. Your application will be considered without regard to race, color, sex, age, handicap, religious creed, national origin or political beliefs. These are equal opportunity programs. If you believe you have been discriminated against, you may file a complaint with the Civil Rights Coordinator, Human and Community Services Division, Department of Public Health and Human Services, P.O. Box 202952, Helena, Montana 59620-2952.
8. In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. For Food Stamps, to file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9400 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

WORK REQUIREMENTS: FOR FOOD STAMPS ONLY:

1. Individuals who are physically and mentally fit and between the ages of **16 and 60** shall be **ineligible** if they: (1) refuse without good cause to provide sufficient information to allow a determination of their employment status or job availability; (2) voluntarily and without good cause quit a job; or (3) voluntarily and without good cause reduce their work effort (and after the reduction, are working less than 30 hours a week).
2. Individuals who reside in a county with a Food Stamp Employment and Training Program may be required to attend this program.
3. TANF cash assistance work requirements do not apply to Food Stamps.

TIME LIMITED BENEFITS:

1. The household may not be eligible for TANF cash assistance benefits if a member of the household has received 60 months of TANFcash assistance benefits in any state. TANF time limits do not apply to Medicaid or Food Stamps.
2. An individual who is an able bodied adult without dependents, may not be eligible for Food Stamp benefits if they have received 3 months of Food Stamp Benefits in a 36 month period, unless they meet an exemption, or meet the work requirement.

PENALTIES: FOOD STAMP AND TANF CASH ASSISTANCE PROGRAMS:

1. It is unlawful for you to knowingly make false statements, misrepresent facts, or conceal information to obtain benefits.
2. Individuals who knowingly and intentionally break a rule can be prosecuted and fined. Under the Food Stamp Program, the fine may be up to $250,000 or you may be imprisoned up to 20 years, or both. Individuals are also subject to prosecution under other applicable federal laws.
3. Any household member who knowingly and intentionally breaks a Food Stamp or TANF cash assistance rule can be barred from the program for 1 year for the first violation; for 2 years for the second violation; and permanently disqualified after the third violation.
4. Any Food Stamp recipient who has been found guilty in a federal, state or local court of trading food coupons for controlled substances (illegal drugs or certain drugs for which a doctor’s prescription is required) will be disqualified from participation in the Food Stamp program for 2 years for the first offense and permanently for the second offense.
5. Any Food Stamp recipient who has been found guilty in a federal, state or local court of trading food coupons for firearms, ammunition, or explosives will be permanently disqualified from participation in the Food Stamp Program.
6. An individual shall be permanently disqualified from participation in the Food Stamp program if he/she is convicted of trafficking Food Stamp benefits of $500 or more.
7. An individual shall be ineligible to participate in the Food Stamp program for 10 years if he/she is found to have made a fraudulent statement or representation with respect to identity and/or residence in order to receive multiple benefits simultaneously.
8. For TANF cash assistance, an individual shall be ineligible to participate in the TANF cash assistance program for 10 years if he/she is found to have made a fraudulent statement or representation with respect to where they live or benefits received in another state in order to receive multiple benefits simultaneously.

*1. **Are you a Montana resident?. . . . . ☐ Yes ☐ No**

If YES, please check how long. ☐ Less Than 1 Month ☐ 1-6 months ☐ 6-12 months ☐ over 12 months

*2. **If you have lived in Montana 12 months or less, list the state you came from:**_____

Please check *one reason* why you moved to Montana:

☐ Work ☐ Like Montana ☐ Relatives ☐ Cash Assistance time limits used up in another state ☐ Other

Please list the household member, state and total number of months all adults in the household received cash assistance (AFDC, TANF or FAIM Financial) since October 1, 1996.

HOUSEHOLD MEMBER NAME	STATE	NUMBER OF MONTHS	HOUSEHOLD MEMBER NAME	STATE	NUMBER OF MONTHS

Have you, or any member of your household, lived on an Indian Reservation for any period of time since August 22, 1996? . . . . . ☐ Yes ☐ No

If yes, did you, or any member of your household, receive cash benefits while residing on an Indian Reservation? . . . . . ☐ Yes ☐ No

* 3. **List the name, address and telephone number of anyone who acts as a legal guardian or has power of attorney for any household member. *Bring Copy of Legal Document*** (See Question # 4 below to designate an authorized representative for Food Stamps, if desired.)_____

_____

4. **You can choose an AUTHORIZED REPRESENTATIVE to help you with your Food Stamp assistance, your Medicaid assistance or your cash assistance. List their name, address, and telephone number below.**

Last Name	First Name Middle Initial	Phone
Street	City	Zip

Do you need your authorized representative to help you with your cash assistance or Medicaid card? ☐ Yes ☐ No
Do you want your authorized representative to help you apply for your Food Stamp assistance?. . . . ☐ Yes ☐ No
Do you want your authorized representative to receive your Food Stamps and use them to buy food for you?. . . . . ☐ Yes ☐ No
Do you want your authorized representative to receive copies of your letters or notices? . . . . . ☐ Yes ☐ No

5. **Is any household member temporarily out of the home? . . . . . ☐ Yes ☐ No**
If yes, list name, date left, date to return, where person went (such as in the hospital, away at school, looking for work, etc.)_____

_____

#6. **Do you share your home with others not listed on the front page? . . . . . ☐ Yes ☐ No**
If so, please list names: _____

#7. **Does anyone in your household purchase and prepare food separately from other household members? . . . . . ☐ Yes ☐ No**
If YES, please list whom. _____

8. **Has anyone listed on page 1 used another name (e.g. maiden name) or social security number? ☐ Yes ☐ No**
If yes, please provide details._____

_____

9. **Is any household member currently attending school? . . . . . ☐ Yes ☐ No**

If yes, who?_____

COUNTY USE ONLY:

10. **OPTIONAL**: **Complete the chart below for anyone in the household who is Hispanic or Latino**. This information will not be used to consider your eligibility for benefits. If you do not answer, your worker will complete this section. Questions about ethnic background are authorized by Title VI of the Civil Rights Act of 1964.

Name	**HB** Hispanic Black	**HW** Hispanic White

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

11. **OPTIONAL**: **Please enter the racial heritage of any person not listed in question 10**. If the person is multiracial, you may enter all codes that apply. This information will not be used to consider your eligibility for benefits. If you do not answer, your worker will complete this section. Questions about ethnic background are authorized by Title VI of the Civil Rights Act of 1964.

Name	**AI** American Indian/Alaskan Native	**AS** Asian	**PI** Pacific Islander	**BL** Black	**WH** White

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

*12. **If anyone in the household is an enrolled tribal member, enter person's name, name of tribe, and tribal enrollment number.**

Name	**Tribal Name**	**Tribal Enrollment Number**

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

13. **Is anyone in your household a boarder (pays for room and meals)? . . . . . ☐ Yes ☐ No**

If YES, please list who._____

14. **Is anyone who is age 16 or older unable to work or disabled because of physical or mental problems? . . . . . ☐ Yes ☐ No**
If YES, please list whom, the medical problem, and the source of any disability payments received. (If a payment is not being received, doctor's statement may be required.)_____
_____

15. **Is any household member unable to work outside the home due to caring for a disabled household member? . . . . . ☐ Yes ☐ No**

If YES, please list who provides care (provide verification). _____

Who is cared for?_____

*16. **Is anyone applying for assistance an alien (not a US Citizen)? . . . . . ☐ Yes ☐ No**

If YES, what is the alien status (and date of entry) of all aliens in the household?
Alien Name/Status: _____

If the alien has a sponsor, list the sponsor's name and address._____
_____

17. **Put a check mark in the box in front of the property/account owned by household members (including children). Include property/account jointly owned with others in or outside the household.**

- ☐ Bank Account(s) - PC / SV / CU / BC / IT / ID
- ☐ Cash - CA
- ☐ Individual Indian Money Accounts (IIM) - IM
- ☐ Retirement Accounts - IR / PE / MR
- ☐ Certificates of Deposit (CD) - CD
- ☐ Stocks / Bonds - ST / BO
- ☐ Trust Funds - TI / TF
- ☐ Other (Specify) _____
- ☐ None

For all items checked, fill in the boxes below.

Names of Financial Institutions	Type of Property/Account	Owner(s)/Joint Owner(s)	Amount

18. **Put a check mark in the box in front of the property owned or being purchased by any household member. Include property co-owned with others in or outside the household.**

- ☐ The Home You Live In (Include mobile homes) - HM
- ☐ Camper / Trailer (other than the home you live in) - TR
- ☐ Life Insurance (List all policies) - LI (Optional if applying for food stamps only)
- ☐ Farm / Business Equipment - FE
- ☐ Livestock - LV
- ☐ Tools / Equipment for work - TT
- ☐ Other Houses, Land or Buildings - HS, RE
- ☐ Income Producing Property - IP
- ☐ Contracts for Deed
- ☐ Burial Trust/Contracts/Policies
- ☐ Life Estates - LE
- ☐ Mineral Rights (oil, gas, coal, etc.)
- ☐ Other (Specify)_____
- ☐ None

For all items checked, fill in the boxes below.

Owner(s)/Joint Owners	Type of Property/Account	Value	Amount Owed	Location/Account Number	For Sale Yes/No	Equity

19. **Put a check mark in the box in front of all vehicles owned or being purchased by any household member. Include vehicles owned with others in or outside the household.**

- ☐ Car - CA
- ☐ Truck - TR
- ☐ Motorcycle - MC
- ☐ Snowmobile - SM
- ☐ Boat and/or Boat Motor - BO
- ☐ Motor Home or Recreational Vehicle - MH
- ☐ Other Vehicles (Specify)_____
- ☐ None

Fill in the boxes below for all vehicles, whether operable or licensed.

Year	Make	Model	Owner(s)/Joint Owner(s)	Licensed or	Amount	County Use

20. **List any vehicles, money, property or other assets sold, traded or given away by any household member, within the last 3 months for Food Stamp applications or within the last 5 years for other assistance programs.**

If yes, list the item; the date it was sold, traded, or given away; the person who sold, traded or gave away the item.

_____

_____

21. **Put a check mark in the box in front of all unearned income (not from employment) received by any household members.**

- ☐ Social Security - SS
- ☐ Supplemental Security Income (SSI) - SI
- ☐ Unemployment Insurance - UI
- ☐ Worker's Compensation - WC
- ☐ Child Support / Alimony - CS
- ☐ Gifts / Contributions
- ☐ Assistance Payments from a Tribe or Other State - AP
- ☐ General Assistance (includes County or BIA) - GA
- ☐ Interest / Dividends - DI
- ☐ Veterans Benefits - VA
- ☐ Military Allotment - MI
- ☐ Retirement Benefits / Pensions - RR / OP
- ☐ Lease Income - LE
- ☐ Royalties - RO
- ☐ Foster Care Payments - FC
- ☐ Insurance Settlement
- ☐ Loans - LO
- ☐ Temporary Disability Insurance - TD
- ☐ Other *(Specify)* _____
- ☐ None

For all items checked, fill in the boxes below

Name	Type of Income	How Often Paid	Amount

22. **Has anyone in your household *applied for or received* Unemployment Insurance (UI) or Workers' Compensation (WC) within the last 12 months? . . . . . ☐ Yes ☐ No**
If YES, fill in the boxes below.

UI ☐ WC ☐	UI ☐ WC ☐
Name: _____	Name: _____
Start Date: _____ End Date: _____	Start Date: _____ End Date: _____
Reason Terminated/Denied: _____	Reason Terminated/Denied: _____
Received During Past 12 Months: ☐ Yes ☐ No	Received During Past 12 Months: ☐ Yes ☐ No

23. **Mark the box and list the amount of student financial aid applied for or received within the last 12 months by any household member.**

- ☐ Student Loan $_____
- ☐ PELL $_____
- ☐ Bureau of Indian Affairs $_____
- ☐ Veteran Assistance $_____
- ☐ Scholarships $_____
- ☐ Other (include family, work study, church, employer, etc.) $_____

24. **Does anyone expect to receive money before the end of the next calendar month (such as a settlement from a legal action, child support, retirement, pensions, disability, or accident insurance)?. . . . . ☐ Yes ☐ No**

If YES, list what it is and who will be receiving the money. _____
_____

COUNTY USE ONLY: Date of Accident: _____

Name of Person Injured: Lawyer Name:

Person or insurance company who is or may be responsible for paying any of these medical costs: _____
_____

Contributions/Gifts: Request information regarding amount of gift received - check policy.

UNIN

25. **Is anyone in the household currently working or has worked in the past 30 days?. . . . . ☐ Yes ☐ No**

List all household members who **have worked, will work or are currently working any kind of job *this month*, or will receive wages *this month* due to work done in a previous month**. Include: Present Employment (full-time and part-time) -- Spot Jobs -- Tips -- Commissions -- Work Study

	Complete a column for each job held by any household member		
PERSON EMPLOYED			
THIS MONTH'S TOTAL WAGES BEFORE TAXES			
BUSINESS NAME			
BUSINESS ADDRESS			
BUSINESS PHONE			
DATE JOB STARTS			
AVERAGE HOURS PER WEEK			
PAY PER HOUR			
AVERAGE TIPS PER SHIFT			
HOW OFTEN PAID			
DATES PAY RECEIVED			
ENDING PAY PERIOD DATE			

PLEASE PROVIDE WAGE VERIFICATION FOR THIS MONTH AND LAST MONTH

*26. **Do you or any household member expect a change in earnings or number of hours worked (i.e., vacation, seasonal employment) before the end of the next calendar month?. . . . . ☐ Yes ☐ No**

If YES, please explain._____

_____

27. **Has anyone in your household stopped working or reduced work hours in the last 60 days?. . . ☐ Yes ☐ No**

If YES, fill in the boxes below, and include any wages paid ***this month*** in question 24.

Name		Name of Employer	Date Left Job or Reduced Hours
Date & Amount of Final Check	Reason for Leaving	Is it a Temporary Layoff?	Date Expected to Return to Work

Use separate sheet for additional persons.

#28. **Is anyone in your household on strike?. . . . . ☐ Yes ☐ No**

If YES, please list who, when the strike began, employer's name and amount of strike income._____

_____

_____

29. **Is anyone in the household self-employed? . . . . . ☐ Yes ☐ No**

If YES, list the name of the business, who owns it and kind of business it is ._____

_____

PLEASE PROVIDE SELF EMPLOYMENT RECORDS

30. **Is anyone in your household working in exchange for any living expense or housing cost(s)?. . ☐ Yes ☐ No**

If YES, please explain._____

_____

_____

31. List expenses for which you are billed, and responsible to pay. **If you do not report and verify expenses, the expense deduction will not be allowed.** If anyone outside the household pays any expense for the household, please write their name in the last column.

Item	Code	Current Total Monthly Cost	Household's Share	Who Assists in Paying the Expense?
Rent	**RE**	$		
Lot Rent	**LR**	$		
Mortgage	**MO**	$		
Property Taxes (if separate from mortgage)	**TX**	$		
Home Insurance (if separate from mortgage)	**HO**	$		
Electricity	**EL**	$		
Natural Gas/Propane	**GP**	$		
Oil	**OI**	$		
Wood/Coal/Other Heat Source	**WO/**	$		
Water/Sewer	**WA**	$		
Garbage/Trash	**GB**	$		
Basic Phone Rate (do not include long distance calls)	**TL**	$		
Utility Installation Fee (not deposit)	**UI**	$		
Dependent Care (adult or child)	**DC**	$		
Child Support	**CS or CH**	$		
* Alimony/Spousal Support		$		
Medical Insurance Premiums	**HI**	$		
Medical Payments/Bills (elderly or disabled only)	**ME**	$		
Medicare Premiums	**MC or MB**	$		
Other Expenses *(Specify)*	**OT**	$		

#32. **Are you approved for or receiving LIEAP?** (LIEAP = Low Income Energy Assistance Program)**. . . . . ☐ Yes ☐ No**

#33. **Do you pay heating or cooling costs?. . . . . ☐ Yes ☐ No**

#34. **Choose one deduction: ____ Standard Utility Allowance (SUA) ____ Actual Utility Costs**

Standard Utility Allowance (SUA) -- The SUA is a standard deduction amount which reflects the statewide average amount spent for specific utilities. If you are responsible to pay for heating or cooling costs, you may choose to use the SUA, which stays the same each month. If you receive LIEAP, you may choose the SUA even if you do not pay your own heating costs. (Ask your worker for the current SUA or if you have questions.)

Actual Utility Costs -- If you choose to use Actual Costs, you will need to verify these costs or no deduction will be allowed.

COUNTY USE ONLY:

35. **If you indicated a dependent care expense above, please complete the following:**

	COMPLETE A COLUMN FOR EACH PERSON RECEIVING CARE			
PERSON RECEIVING CARE				
NAME OF PERSON PAYING FOR CARE/AMOUNT PAID				
NAME OF PROGRAM PAYING/AMOUNT PAID				
NAME OF PERSON PROVIDING CARE				
ADDRESS OF PERSON PROVIDING CARE				
AMOUNT BILLED				
DATE PAID				
ESTIMATE # OF HOURS OF CARE/MONTH				
REASON FOR CARE	☐ Work ☐ Training/School ☐ Looking for Work	☐ Work ☐ Training/School ☐ Looking for Work	☐ Work ☐ Training/School ☐ Looking for Work	☐ Work ☐ Training/School ☐ Looking for Work

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

COMPLETE THE BLUE SECTION (QUESTIONS 36 THROUGH 43) IF YOU ARE APPLYING FOR MEDICAID.

*36. **Is anyone in your home pregnant?** . . . . . ☐ **Yes** ☐ **No**

If YES, please list who and the expected date of birth. (Medical proof of pregnancy will be required.)

_____

*37. **Do you want EPSDT services for anyone under age 21? (See following information).** . . . . . ☐ **Yes** ☐ **No**

ATTENTION: *ALL MEDICAID APPLICANTS*

All Medicaid recipients under 21 years of age are eligible for the Early Periodic Screening Diagnostic Treatment (EPSDT) Program. This program emphasizes preventive health care and offers a comprehensive well-child examination. The examination includes:

- ! measurement of height and weight
- ! blood pressure test
- ! lab tests
- ! hearing test
- ! growth and developmental assessment
- ! immunizations
- ! dental exam
- ! vision test

The EPSDT Program also offers follow-up diagnosis and treatment for any problems found.

*38. **Does anyone in the household have medical benefits through either Medicare (Part A or B) or railroad retirement coverage?** . . . . . ☐ **Yes** ☐ **No**

If YES, please list their name(s) and provide verification._____

*39. **Is a group health insurance plan available to anyone in your household?** . . . . . ☐ **Yes** ☐ **No**
Is coverage available through an absent parent? . . . . . ☐ **Yes** ☐ **No**
Is anyone in your household enrolled in the insurance? . . . . . ☐ **Yes** ☐ **No**

*40. **Is anyone in the household covered by health/dental insurance?** . . . . . ☐ **Yes** ☐ **No**

If YES, fill in the boxes below. For additional policies, please attach a sheet containing this information.

Policyholder's Name	SSN	Policy #	Amount Paid $ _____ Per _____ (Month, Quarter, Semi-Annual, Year)	
Insurance Company (List Name and Address)		Group #		
		Persons Covered	Start Date	End Date

*41. **Does anyone in the household have medical bills for services received during the last three months? OR Any unpaid medical bills for services received at any time? . . . .** ☐ Yes ☐ No
(If YES, bring all medical bills indicated above)

*42. **Did anyone in your home once receive SSI which later stopped? . . . .** ☐ Yes ☐ No
Does this person now receive Social Security benefits? . . . . ☐ Yes ☐ No

If YES, please list whom and the date of their last SSI check. ______________________________

*43. **If you are approved for Medicaid, are you interested in receiving a discount on your telephone bills?. . . . .** ☐ Yes ☐ No

If YES, whose name is your telephone service listed in?______________________________

COMPLETE THE ORANGE SECTION (QUESTIONS 44 and 45) IF YOU ARE APPLYING FOR FOOD STAMPS.

#44 **Does anyone in your household receive Tribal food commodities? . . . .** ☐ Yes ☐ No
If "Yes", whom? ______________________________

#45 **Have you, or any member of your household, ever been disqualified from the Food Stamp Program? . . . .** ☐ Yes ☐ No
If YES, list the persons name, date it happened, date disqualified, and how long was the disqualification period._____
____
____

COMPLETE THE GREEN SECTION (QUESTIONS 46 THROUGH 48) IF YOU ARE APPLYING FOR TANF CASH ASSISTANCE.

#*46. **Does any agency help you in paying your shelter costs? . . . .** ☐ Yes ☐ No

If YES, please put a check mark in front of the type of assistance received:

___Public Housing -- Housing units or buildings owned or under the control of the public housing authority.

___Rent Subsidy -- Any other form of housing in which money is paid from a government-funded housing program.

Amount you pay: $______________________________

#*47.**Is anyone paying or billed for the care of a dependent child or disabled adult so someone can work, attend training/school, or look for work? . . . .** ☐ Yes ☐ No
If YES, indicate the child care provider type as explained below:

PROVIDER TYPES
In-home day care: . . . . Child care provided in the child's home.
Family day care home: . Child care provider caring for 3 - 6 children.
Group day care home: Child care provider caring for 7 - 12 children.
Day Care Center: . Child care provider caring for 13 or more children.

CHILD'S NAME	CHILD CARE PROVIDER TYPE	IS THE CHILD CARE		IS THE CHILD CARE PROVIDER		
	__ In-home day care __ Family day care home __ Group day care home __ Day Care Center	**HDC** **FDC** **GDC**	___ Yes ___ No	**LHR** **LFR** **LGR**	___ Yes ___ No	**LHN** **LFN** **LGN**
	__ In-home day care __ Family day care home __ Group day care home __ Day Care Center	**HDC** **FDC** **GDC**	___ Yes ___ No	**LHR** **LFR** **LGR**	___ Yes ___ No	**LHN** **LFN** **LGN**
	__ In-home day care __ Family day care home __ Group day care home __ Day Care Center	**HDC** **FDC** **GDC**	___ Yes ___ No	**LHR** **LFR** **LGR**	___ Yes ___ No	**LHN** **LFN** **LGN**

IF MORE SPACE IS NEEDED, ATTACH A SEPARATE SHEET

#*48. **Enter the appropriate education level and status for each household member as follows:**

EDUCATION LEVEL	EDUCATION STATUS
Enter the highest grade **COMPLETED** for each household member of any age **or** enter one of the following codes for household members who have not yet started or never attended school: **PS** Pre-school **HS** Head start **KI** Kindergarten	Enter the appropriate education status for all household members sixteen (16) years of age or older from the following code table: **H** GED/High School Diploma **A** Associate Degree **B** Bachelor Degree **M** Master Degree **O** Other Degree

NAME	EDUCATIONAL LEVEL	EDUCATION STATUS

* 49. **Do you expect any changes before the end of the next calendar month in the information you gave us today? . . . . . ☐ Yes ☐ No**

If YES, please explain. _____

_____

_____

50. **If you are not registered to vote where you live now, would you like to apply to register to vote today? . . . . . ☐ Yes ☐ No**

If you do not check either of these boxes, you will be considered to have decided not to register to vote at this time.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you believe that someone has interfered with your right to register to vote or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the Secretary of State, PO Box 202801, Helena, MT 59620-2801; toll free telephone number: 1-888-884-8683

ADDITIONAL INFORMATION

READ CAREFULLY BEFORE SIGNING.
IF YOU DO NOT UNDERSTAND SOMETHING, ASK YOUR WORKER ABOUT IT.

I UNDERSTAND THAT:

G I must report to the Department of Public Health and Human Services (DPHHS) local office any changes in my situation. Changes must be reported within 10 days of knowledge. Late reporting may cause incorrect benefits. [For Food Stamps report: changes in source of income or amount of income of more than $25 (except changes in TANF cash assistance); changes in household composition; changes in residence and resulting change in shelter costs; acquisition of licensed vehicle; when cash, stocks, bonds, money in bank reach or exceed a total of $3,000.]

G I must provide information and proof as requested to help determine that I am eligible for assistance. DPHHS may help me obtain the proof or contact other persons or agencies to assist me.

G **The information I (we) give here is subject to verification by federal and state officials. If any information is incorrect, my application may be denied and I may be subject to the criminal penalties for knowingly providing incorrect information.**

G My (our) Social Security Number(s) will be used by state and federal agencies to check identity of household members, to prevent duplicate participation, and to exchange information by computer with other agencies (Social Security Administration, Internal Revenue Service, employers, and banks). The information obtained from these sources may affect my eligibility or benefit level.

G My (our) alien status information will be verified with Immigration and Naturalization Services (INS) for Food Stamp and TANF cash assistance. This information may affect eligibility or level of benefits.

G By asking for and receiving TANF cash assistance, or Food Stamp benefits, adults may be required to participate in an employment or training activity.

G Federal and State laws and regulations limit the use and disclosure of confidential information about applicants and recipients of assistance programs.

G If approved for Medicaid, my (our) rights to any health insurance or other third party payment are automatically assigned by law to the State of Montana.

G Under Montana law, medical assistance paid on behalf of individuals age 55 or older or anyone who lived in a nursing home (regardless of age) may be subject to recovery from the individual's estate. Additionally, a lien may be placed on any real property owned by an individual who receives medical assistance for nursing home services.

G I may request a Fair Hearing if I disagree with any action taken on my case. For Food Stamps, the request may be orally or in writing. For other assistance programs, the request must be in writing.

Required for applicants for all programs:

I understand the questions on this application and the penalty for withholding or giving false information or breaking any of the rules listed in the penalty warning. I understand and agree to provide documents to prove what I have said. I understand and agree that the agency may contact other persons or organizations to obtain necessary verification of any statements on this application.

I certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member.

YOUR SIGNATURE	TODAY'S DATE	WITNESS SIGNATURE (If applicant signed with an X)

* Signature(s) of **ALL** other individuals age 18 or older who live with you (if applying for cash assistance or Medicaid):

Name	Relationship to Applicant	Date

COUNTY USE ONLY:

_____ was interviewed by_____
Name of Applicant or Authorized Representative — Name of OPA Case Manager

on _____ _____
Date — Application Effective Date

COUNTY USE ONLY:

Date of Application: _____

Your personal or group interview is scheduled for: Date: _____ Time: _____

If you cannot keep your scheduled interview appointment (if needed), YOU MUST SCHEDULE ANOTHER APPOINTMENT WITHIN 30 DAYS OF THE APPLICATION DATE.

VERIFICATION

The following is a list of verifications to bring to the interview which may speed up the application process:

Identity:

- Birth certificate
- Driver's license
- Tribal Enrollment card
- Baptismal certificate
- Voter Registration card
- Work or School ID

Social Security Numbers:

- You must be able to provide a Social Security number or proof that you have applied for a number for all individuals requesting assistance

Citizenship/Alien Status:

- Birth certificate
- Alien Registration card
- Baptismal certificate
- INS forms

Income and Resources:

- Pay stubs, pay envelopes, earnings statements from employers
- Award letters for Social Security, Supplemental Security Income, Unemployment Insurance benefits, Worker's Compensation, Veteran's Administration benefits, pensions, etc.
- Child Support and/or alimony stubs or payment records
- Bank statements for checking accounts and savings accounts
- Financial statements for certificates of deposit or stocks and bonds
- Federal income tax returns, bookkeeping records, expense records
- Rental income or sales contract records/ledgers
- Life insurance and/or burial policies
- Award notices for educational loans, scholarships and grants
- Statements of loans, gifts or contributions that you have received
- Automobile/equipment statements of loans or balance due
- Vehicle registrations and titles

Expenses:

- Rent receipt/mortgage payment (including home mortgage insurance and property taxes) (Not required for Medicaid)
- Dependent care bills and receipts
- Medical expense bills or statements (medication, doctor bills, hospital bills, insurance premiums). Include copies of Medicare and health insurance explanation of benefits/payment statements.
- Receipts for higher education expenses

Other:

- Doctor's statement of pregnancy and due date
- Copy of certified divorce decree/legal separation
- Medicare card showing eligibility for Medicare Part A and/or B
- Health insurance policies
- Commodity release (For Food Stamps only)
- School enrollment

ADDITIONAL INSTRUCTION